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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 1/14/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Rhizotomy (Rt), L5, S1, S2, S3 levels, outpatient, under anesthesia, with fluoroscopic guidance

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Pain Management & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
Overturned	**(Disagree) X**
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
This individual was injured in xx/xxxx where she sustained a lifting injury. There is persistent pain in the lower back. Physical examination is suggestive of right SI joint dis-function. A local anesthetic/steroid injection of the SI joint provided “excellent pain relief”. The request is for radio frequency ablation of the right L5, S1, S2, and S3.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: I disagree with the benefit company's decision to deny the requested service(s).

Rationale: ODG updated 10/09/14 does not recommend the procedure although it references a peer review journal (see page 4) which states that there is some evidence to support this procedure although the evidence is limited. This individual meets the the criteria for SI joint dis-function; has had a diagnostic block with temporary relief. Even though the literature is limited supporting the procedure, there *is* literature that indicates efficacy of the procedure. In clinical practice there is significant relief achieved in a large percentage of these individuals. Therefore, I recommend the procedure as requested.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE X

(PROVIDE DESCRIPTION)

* **"American Society of Interventional Pain Physicians" (Hansen, 2007)**

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)